

Facility Name & ID Number Brentwood North Healthcare & Rehabilitation Ctr

0050112 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	248	Skilled (SNF)	248	90,520	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,520	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	1,139	2,653	16,304	20,096	8	
9	SNF/PED					9	
10	ICF	14,625	8,707	50	23,382	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	15,764	11,360	16,354	43,478	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.03%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 9/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/01/2008 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 248 and days of care provided 12,994

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Brentwood North Healthcare & Rehabilitation # 0050112 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	390,973	39,755	1,004	431,732		431,732		431,732		1
2	Food Purchase		408,927		408,927	(28,643)	380,284		380,284		2
3	Housekeeping		7,431	278,994	286,425		286,425		286,425		3
4	Laundry			186,209	186,209		186,209		186,209		4
5	Heat and Other Utilities			266,571	266,571		266,571	3,453	270,024		5
6	Maintenance	103,579	40,195	96,921	240,695		240,695	6,969	247,664		6
7	Other (specify):* Allocated Employee Benefits							271	271		7
8	TOTAL General Services	494,552	496,308	829,699	1,820,559	(28,643)	1,791,916	10,693	1,802,609		8
	B. Health Care and Programs										
9	Medical Director			50,000	50,000		50,000		50,000		9
10	Nursing and Medical Records	3,747,566	467,449	6,161	4,221,176		4,221,176	(50,682)	4,170,494		10
10a	Therapy	72,825	2,408	1,281,636	1,356,869		1,356,869	(153,976)	1,202,893		10a
11	Activities	137,980	7,941	960	146,881		146,881		146,881		11
12	Social Services	57,986		3,070	61,056		61,056		61,056		12
13	CNA Training										13
14	Program Transportation			1,359	1,359		1,359		1,359		14
15	Other (specify):* Allocated Employee Benefits							126,101	126,101		15
16	TOTAL Health Care and Programs	4,016,357	477,798	1,343,186	5,837,341		5,837,341	(78,557)	5,758,784		16
	C. General Administration										
17	Administrative	95,906		828,354	924,260		924,260	(812,401)	111,859		17
18	Directors Fees										18
19	Professional Services			43,037	43,037		43,037	(4,942)	38,095		19
20	Dues, Fees, Subscriptions & Promotions			38,942	38,942	2,190	41,132	6,204	47,336		20
21	Clerical & General Office Expenses	373,864	62,203	40,529	476,596	(2,190)	474,406	247,031	721,437		21
22	Employee Benefits & Payroll Taxes			645,638	645,638	28,643	674,281		674,281		22
23	Inservice Training & Education			1,970	1,970		1,970	4,988	6,958		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			12,970	12,970		12,970	(1,605)	11,365		25
26	Insurance-Prop.Liab.Malpractice			125,868	125,868		125,868	4,214	130,082		26
27	Other (specify):* Allocated Employee Benefits							39,624	39,624		27
28	TOTAL General Administration	469,770	62,203	1,737,308	2,269,281	28,643	2,297,924	(516,887)	1,781,037		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,980,679	1,036,309	3,910,193	9,927,181		9,927,181	(584,751)	9,342,430		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			9,697	9,697		9,697	864,146	873,843			30
31	Amortization of Pre-Op. & Org.							47	47			31
32	Interest			24,912	24,912		24,912	(24,912)				32
33	Real Estate Taxes							152,047	152,047			33
34	Rent-Facility & Grounds			1,550,814	1,550,814		1,550,814	(1,550,814)				34
35	Rent-Equipment & Vehicles			21,559	21,559		21,559	3,058	24,617			35
36	Other (specify):*											36
37	TOTAL Ownership			1,606,982	1,606,982		1,606,982	(556,428)	1,050,554			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		635,726	47,076	682,802		682,802		682,802			39
40	Barber and Beauty Shops			12,221	12,221		12,221		12,221			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,412	131,412		131,412		131,412			42
43	Other (specify):* Non-Allowable			130,457	130,457		130,457	(130,457)				43
44	TOTAL Special Cost Centers		635,726	321,166	956,892		956,892	(130,457)	826,435			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,980,679	1,672,035	5,838,341	12,491,055		12,491,055	(1,271,636)	11,219,419			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,449)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(118,170)	43		24
25	Fund Raising, Advertising and Promotional	(7,678)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule F:	(1,206,537)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,336,834)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	65,198		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 65,198		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,271,636)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Brentwood North Healthcare & Rehabilitation Ctr

ID# 0050112

Report Period Beginning: 1/01/2010

Ending: 12/31/2010

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Adjust Mgt Co. medical supplies "A" to cost	\$ (20,188)	10	1
2	Adjust Mgt Co. medical supplies "other" to cost	(30,494)	10	2
3	Non-allowable Illinois Council on Long Term Care Dues	(8,610)	20	3
4	Non-allowable patient clothing	(160)	43	4
5	Non-allowable professional fees	(24,995)	19	5
6	Non-allowable owner interest expense	(1,092,819)	32	6
7	Non-allowable owner interest expense	(24,912)	32	7
8	Non-allowable auto expense - marketing	(4,359)	25	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,206,537)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brentwood North Healthcare & Rehabilitation Ctr# 0050112

Report Period Beginning:

1/01/2010

Ending:

12/31/2010

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,453	0	0	0	0	0	0	0	0	3,453	5
6	Maintenance	0	0	6,940	0	29	0	0	0	0	0	0	6,969	6
7	Other (specify):*	0	0	271	0	0	0	0	0	0	0	0	271	7
8	TOTAL General Services	0	0	10,664	0	29	0	0	0	0	0	0	10,693	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(50,682)	0	0	0	0	0	0	0	0	0	0	(50,682)	10
10a	Therapy	0	0	0	0	(153,976)	0	0	0	0	0	0	(153,976)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	126,101	0	0	0	0	0	0	126,101	15
16	TOTAL Health Care and Programs	(50,682)	0	0	0	(27,875)	0	0	0	0	0	0	(78,557)	16
	C. General Administration													
17	Administrative	0	0	(812,401)	0	0	0	0	0	0	0	0	(812,401)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(24,995)	0	19,334	0	719	0	0	0	0	0	0	(4,942)	19
20	Fees, Subscriptions & Promotions	(8,610)	0	486	0	14,328	0	0	0	0	0	0	6,204	20
21	Clerical & General Office Expenses	0	0	228,487	0	18,544	0	0	0	0	0	0	247,031	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	312	0	4,676	0	0	0	0	0	0	4,988	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,359)	0	1,848	0	906	0	0	0	0	0	0	(1,605)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,401	0	2,813	0	0	0	0	0	0	4,214	26
27	Other (specify):*	0	0	38,492	0	1,132	0	0	0	0	0	0	39,624	27
28	TOTAL General Administration	(37,964)	0	(522,041)	0	43,118	0	0	0	0	0	0	(516,887)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(88,646)	0	(511,377)	0	15,272	0	0	0	0	0	0	(584,751)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brentwood North Healthcare & Rehabilitation Ctr# 0050112

Report Period Beginning:

1/01/2010 Ending:

12/31/2010

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	5,908	857,825	413	0	0	0	0	0	0	864,146	30
31	Amortization of Pre-Op. & Org.	0	0	47	0	0	0	0	0	0	0	0	47	31
32	Interest	(1,117,731)	0	0	1,092,819	0	0	0	0	0	0	0	(24,912)	32
33	Real Estate Taxes	0	0	2,833	149,214	0	0	0	0	0	0	0	152,047	33
34	Rent-Facility & Grounds	0	0	0	(1,550,814)	0	0	0	0	0	0	0	(1,550,814)	34
35	Rent-Equipment & Vehicles	0	0	3,058	0	0	0	0	0	0	0	0	3,058	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,117,731)	0	11,846	549,044	413	0	0	0	0	0	0	(556,428)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(130,457)	0	0	0	0	0	0	0	0	0	0	(130,457)	43
44	TOTAL Special Cost Centers	(130,457)	0	0	0	0	0	0	0	0	0	0	(130,457)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,336,834)	0	(499,531)	549,044	15,685	0	0	0	0	0	0	(1,271,636)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sidney Glenner	70.00 %	GlenBridge Nursing & Rehabilitation Centre,Ltd.	Niles	SEE ATTACHED SCHEDULE A		
Joshua Ray	30.00 %	GlenCrest Nursing & Rehabilitation Centre,Ltd.	Chicago			
		Glen Elston Nursing & Rehabilitation Centre,Ltd.	Chicago			
		Glen Oaks Nursing & Rehabilitation Centre,Ltd.	Northbrook			
		GlenShire Nursing & Rehabilitation Centre,Ltd.	Richton Park			
		GlenLake Terrace Nursing & Rehabilitation Ctr,Ltd.	Waukegan			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	Total from Page 6A	\$ 828,354	Glen Health and Home Management, Inc.	A	\$ 328,823	\$ (499,531)	1
2	V							2
3	V	Total from Page 6B	1,550,814	Brentwood Healthcare Real Estate LLC.	B	2,099,858	549,044	3
4	V							4
5	V	Total from Page 6C	1,269,308	Therapy Masters, Inc.	C	1,284,993	15,685	5
6	V							6
7	V							7
8	V							8
9	V			OWNERSHIP REFERENCE:				9
10	V			A: Owned 100.00 % by Sidney Glenner through attribution				10
11	V			B: Owned 70.00 % by Sidney Glenner & 30.00 % by Joshua Ray				11
12	V			C: Owned 100.00 % by Sidney Glenner				12
13	V							13
14	Total		\$ 3,648,476			\$ 3,713,674	\$ * 65,198	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 828,354	Glen Health and Home Management, Inc.	A	\$	\$ (828,354) 15
16	V	5 Utilities		Glen Health and Home Management, Inc.	A	3,453	3,453 16
17	V	6 Repairs and Maintenance		Glen Health and Home Management, Inc.	A	5,331	5,331 17
18	V	19 Professional Fees		Glen Health and Home Management, Inc.	A	19,334	19,334 18
19	V	20 Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	486	486 19
20	V	21 Clerical		Glen Health and Home Management, Inc.	A	17,557	17,557 20
21	V	22 Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	38,763	38,763 21
22	V	23 Training and Education		Glen Health and Home Management, Inc.	A	312	312 22
23	V	25 Auto Expenses		Glen Health and Home Management, Inc.	A	1,848	1,848 23
24	V	26 Insurance		Glen Health and Home Management, Inc.	A	1,401	1,401 24
25	V	30 Depreciation		Glen Health and Home Management, Inc.	A	5,908	5,908 25
26	V	31 Amortization		Glen Health and Home Management, Inc.	A	47	47 26
27	V	33 Real Estate Taxes		Glen Health and Home Management, Inc.	A	2,833	2,833 27
28	V	35 Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	3,058	3,058 28
29	V	6 Janitorial Salaries		Glen Health and Home Management, Inc.	A	1,609	1,609 29
30	V	17 Officer's Salaries		Glen Health and Home Management, Inc.	A	15,953	15,953 30
31	V	21 Administrative Salaries		Glen Health and Home Management, Inc.	A	210,930	210,930 31
32	V	22 Employee Benefits		Glen Health and Home Management, Inc.	A	(38,763)	(38,763) 32
33	V	7 Employee Benefits - Janitorial		Glen Health and Home Management, Inc.	A	271	271 33
34	V	27 Employee Benefits - Officer's		Glen Health and Home Management, Inc.	A	2,710	2,710 34
35	V	27 Employee Benefits - Admin		Glen Health and Home Management, Inc.	A	35,782	35,782 35
36	V						
37	V						
38	V						
39	Total		\$ 828,354			\$ 328,823	\$ * (499,531) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	32 Interest Expense	\$	Brentwood Healthcare Real Estate LLC	B	\$ 1,092,819	\$ 1,092,819
16	V	30 Depreciation		Brentwood Healthcare Real Estate LLC	B	857,825	857,825
17	V	33 Real Estate Taxes		Brentwood Healthcare Real Estate LLC	B	149,214	149,214
18	V	34 Rental Income	1,550,814	Brentwood Healthcare Real Estate LLC	B		(1,550,814)
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,550,814			\$ 2,099,858	\$ * 549,044

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10a Therapy	\$ 1,269,308	Therapy Masters, Inc.	C	\$ 1,115,332	\$ (153,976)
16	V	19 Professional Fees		Therapy Masters, Inc.	C	719	719
17	V	20 Licenses, Permits and Inspection		Therapy Masters, Inc.	C	46	46
18	V	20 Employment Fees		Therapy Masters, Inc.	C	14,282	14,282
19	V	21 Clerical Salaries		Therapy Masters, Inc.	C	8,838	8,838
20	V	21 Clerical		Therapy Masters, Inc.	C	9,706	9,706
21	V	22 Employee Benefits and Payroll		Therapy Masters, Inc.	C	127,233	127,233
22	V	23 Training and Education		Therapy Masters, Inc.	C	4,676	4,676
23	V	25 Auto Expenses		Therapy Masters, Inc.	C	906	906
24	V	6 Plant Supplies		Therapy Masters, Inc.	C	29	29
25	V	22 Employee Benefits		Therapy Masters, Inc.	C	(127,233)	(127,233)
26	V	15 Employee Benefits - Therapy		Therapy Masters, Inc.	C	126,101	126,101
27	V	27 Employee Benefits - Clerical		Therapy Masters, Inc.	C	1,132	1,132
28	V	30 Depreciation		Therapy Masters, Inc.	C	413	413
29	V	26 Insurance - Liability		Therapy Masters, Inc.	C	2,813	2,813
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,269,308			\$ 1,284,993	\$ * 15,685

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brentwood North Healthcare & Rehabilitati # 0050112 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sidney Glenner	President	Administrative	70.00 %	184,147	5	7.97 %	Salary	\$ 15,953	Ln 17, Col 7	1
2	Jonathan Glenner	Clerical	Clerical	0.00 %	49,554	3	7.97 %	Salary	4,293	Ln 21, Col 7	2
3	Daniel Glenner	Administrative	Administrative	0.00 %	27,269	3	7.97 %	Salary	2,362	Ln 21, Col 7	3
4	Elliot Glenner	Clerical	Clerical	0.00 %	19,146	3	7.97 %	Salary	1,659	Ln 21, Col 7	4
5	David Weinschneider	Administrative	Administrative	0.00 %	48,907	3	7.97 %	Salary	4,237	Ln 21, Col 7	5
6	Joshua Ray	V.P. of Operations	Administrative	30.00 %	184,147	5	7.97 %	Salary	15,953	Ln 21, Col 7	6
7											7
8											8
9											9
10			See Schedule B								10
11											11
12											12
13								TOTAL	\$ 44,457		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brentwood North Healthcare & Rehabilitation Ctr # 0050112 Report Period Beginning: 1/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Glen Health & Home Management, Inc.
 Street Address 5454 West Fargo Avenue
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 674-5454
 Fax Number (847) 674-8311

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	545,364	7	\$ 43,318	\$ 43,478	\$ 3,453	1
2	6	Repairs and Maintenance	Resident Days	545,364	7	66,872	43,478	5,331	2
3	19	Professional Fees	Resident Days	545,364	7	242,509	43,478	19,334	3
4	20	Licenses, Permits and Inspection	Resident Days	545,364	7	6,093	43,478	486	4
5	21	Clerical	Resident Days	545,364	7	220,225	43,478	17,557	5
6	22	Employee Benefits and Payroll	Resident Days	545,364	7	486,222	43,478	38,763	6
7	23	Training and Education	Resident Days	545,364	7	3,909	43,478	312	7
8	25	Auto Expenses	Resident Days	545,364	7	23,185	43,478	1,848	8
9	26	Insurance	Resident Days	545,364	7	17,573	43,478	1,401	9
10	30	Depreciation	Resident Days	545,364	7	74,104	43,478	5,908	10
11	31	Amortization	Resident Days	545,364	7	589	43,478	47	11
12	33	Real Estate Taxes	Resident Days	545,364	7	35,536	43,478	2,833	12
13	35	Equipment and Vehicle Rental	Resident Days	545,364	7	38,360	43,478	3,058	13
14	6	Janitorial Salaries	Resident Days	545,364	7	20,184	43,478	1,609	14
15	17	Officer's Salaries	Resident Days	545,364	7	200,100	43,478	15,953	15
16	21	Administrative Salaries	Resident Days	545,364	7	2,645,790	43,478	210,930	16
17	22	Employee Benefits	Payroll					(38,763)	17
18	7	Employee Benefits - Janitorial	Payroll					271	18
19	27	Employee Benefits - Officer's	Payroll					2,710	19
20	27	Employee Benefits - Admin	Payroll					35,782	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,124,569	\$ 2,866,074	\$ 328,823	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related Long-Term																			
1	SLG Limited Partnership	X		Mortgage	\$108,054.27	8/28/2008	\$ 15,180,000	\$ 14,746,095	9/01/2033	0.0800	\$ 1,092,819	1							
2							Non-Allowable owner interest expense:				(1,092,819)	2							
3												3							
4												4							
5												5							
Working Capital																			
6	AMJED Trust	X		Working Capital			3,165,000				24,912	6							
7							Non-Allowable owner interest expense:				(24,912)	7							
8												8							
9	TOTAL Facility Related				\$108,054.27		\$ 15,180,000	\$ 17,911,095			\$	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 15,180,000	\$ 17,911,095			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report.		\$	143,000		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	144,214		2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,214		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	148,000		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	149,214		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	157,199			8
	2006	131,410			9
	2007	132,370			10
	2008	139,366			11
	2009	144,214			12
See Attached Schedule G For Calculation Of 2010 Real Estate Tax Accrual.					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2009	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,758 B. General Construction Type: Exterior Brick/Masonry Frame Metal Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Patient Care</u>			\$ <u>2,373,245</u>	1
2	<u>Allocated from Management Company:</u>			<u>6,770</u>	2
3	TOTALS			\$ 2,380,015	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	248	2008		\$ 9,170,327	\$ 361,527	15,30 yrs	\$ 361,527	\$	\$ 841,318
5									
6	See Attached			144,598			3,897	3,897	
7	Schedule J								
8									
Improvement Type**									
9	Rooftop condenser unit	2008		7,920	792	10	792		1,980
10	Ceramic tile installation	2010		3,679	184	10	184		184
11	Elevator hydraulic jack assembly	2010		21,500	1,075	10	1,075		1,075
12	Installation of roof drains and patch roof	2010		11,400	570	10	570		570
13									
14									
15									
16	Leasehold Improvements Allocated from Management Company			14,596			140	140	12,885
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 9,374,020		\$ 368,185	\$ 4,037	\$ 858,012	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,539,925	\$ 502,014	\$ 502,014	\$	5,7,10 years	\$ 1,253,442	71
72	Current Year Purchases	20,294	1,774	1,774		5, 10 years	1,773	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company:	71,508		560	560		69,508	74
75	TOTALS	\$ 2,631,727	\$ 503,788	\$ 504,348	\$ 560		\$ 1,324,723	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management Company:			\$ 13,379	\$	\$ 1,310	\$ 1,310		\$ 5,706	76
77										77
78										78
79										79
80	TOTALS			\$ 13,379	\$	\$ 1,310	\$ 1,310		\$ 5,706	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,399,141	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 867,936	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 873,843	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,907	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,188,441	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A.

9. Option to Buy: YES NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 23,128 Description: Copier \$17,222, Postage \$1,547, Icemaker \$1,200, Dish Machine \$1,590, Alloc Mgt Co:\$1,569

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Management Company:</u>		\$	\$ <u>1,489</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,489</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2011 \$ _____

13. /2012 \$ _____

14. /2013 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to hire only certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln10a,Col 2&3	hrs	\$	8,227	\$ 418,944	\$ 1,629	8,227	\$ 420,573	1
2	Licensed Speech and Language Development Therapist	Ln10a, Col 3	hrs		1,995	107,919		1,995	107,919	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		14,377	742,445	779	14,377	743,224	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescrpts				635,726		635,726	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology and Laboratory Other (specify): <u>Respiratory Therapy</u>	Ln39,Co3 Ln10a,Col 1&3	5,092 hours	72,825	190 hours	47,076 12,328		5,282	47,076 85,153	13
14	TOTAL			\$ 72,825	24,599	\$ 1,328,712	\$ 638,134	29,881	\$ 2,039,671	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Brentwood North Healthcare & Rehabilitation Ctr**

0050112

Report Period Beginning: **1/01/2010**

Ending: **12/31/2010**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2010** (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 260,358	\$ 620,098	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>172,000</u>)	2,814,446	2,814,446	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,233	96,233	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(3,325,894)		8
9	Other(specify): <u>Other Receivables</u>	28,382	28,382	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (126,475)	\$ 3,559,159	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,380,015	13
14	Buildings, at Historical Cost		9,314,925	14
15	Leasehold Improvements, at Historical Cost	59,095	59,095	15
16	Equipment, at Historical Cost	58,722	2,645,106	16
17	Accumulated Depreciation (book methods)	(18,279)	(2,188,441)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 99,538	\$ 12,210,700	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (26,937)	\$ 15,769,859	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,079	\$ 2,079	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,504	12,504	28
29	Short-Term Notes Payable		219,288	29
30	Accrued Salaries Payable	364,276	364,276	30
31	Accrued Taxes Payable (excluding real estate taxes)	968	968	31
32	Accrued Real Estate Taxes(Sch.IX-B)		148,000	32
33	Accrued Interest Payable		90,441	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule E:</u>	206,119	206,119	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 585,946	\$ 1,043,675	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		14,526,807	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 14,526,807	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 585,946	\$ 15,570,482	46
47	TOTAL EQUITY(page 18, line 24)	\$ (612,883)	\$ 199,377	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (26,937)	\$ 15,769,859	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 278,941	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 278,941	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(891,824)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (891,824)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (612,883)	24

* Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Brentwood North Healthcare & Rehabilitation Ctr # 0050112** Report Period Beginning: **1/01/2010**Ending: **12/31/2010****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,894,128	1
2	Discounts and Allowances for all Levels	(4,481,441)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,412,687	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,193,667	6
7	Oxygen	56,811	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,250,478	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	250	12
13	Barber and Beauty Care	16,553	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,048	15
16	Rental of Facility Space		16
17	Sale of Drugs	874,289	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	74,993	19
20	Radiology and X-Ray	17,994	20
21	Other Medical Services	935,033	21
22	Laundry	3,600	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,924,760	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,306	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,306	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,599,231	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,820,559	31
32	Health Care	5,837,341	32
33	General Administration	2,269,281	33
B. Capital Expense			
34	Ownership	1,606,982	34
C. Ancillary Expense			
35	Special Cost Centers	825,480	35
36	Provider Participation Fee	131,412	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,491,055	40
41	Income before Income Taxes (line 30 minus line 40)**	(891,824)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (891,824)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Brentwood North Healthcare & Rehabilitation Ctr**

0050112

Report Period Beginning: **1/01/2010**

Ending:

12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,829	2,077	\$ 99,328	\$ 47.82	1
2	Assistant Director of Nursing	2,037	2,246	56,976	25.37	2
3	Registered Nurses	48,744	52,663	1,487,211	28.24	3
4	Licensed Practical Nurses	21,992	23,364	484,522	20.74	4
5	CNAs & Orderlies	96,705	106,164	1,396,296	13.15	5
6	CNA Trainees					6
7	Licensed Therapist	4,315	5,092	72,825	14.30	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,985	2,086	42,230	20.24	9
10	Activity Assistants	6,548	7,252	95,750	13.20	10
11	Social Service Workers	2,898	3,106	57,986	18.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,939	6,751	110,301	16.34	14
15	Cook Helpers/Assistants	22,569	25,333	280,672	11.08	15
16	Dishwashers					16
17	Maintenance Workers	3,672	4,150	103,579	24.96	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,933	2,092	95,906	45.84	20
21	Assistant Administrator					21
22	Other Administrative	14,332	15,699	373,864	23.81	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,929	4,197	111,041	26.46	31
32	Other Health C: Dialysis Techs	4,436	5,170	87,901	17.00	32
33	Other(specify) <u>Ward Clerks</u>	1,755	1,925	24,291	12.62	33
34	TOTAL (lines 1 - 33)	245,618	269,367	\$ 4,980,679 *	\$ 18.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 1,004	Ln 1, Col 3	35
36	Medical Director	Monthly	50,000	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,673	Ln10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	960	Ln11, Col 3	44
45	Social Service Consultant	54	3,070	Ln12, Col 3	45
46	Other(specify)				46
47	<u>Medical Librarian</u>	Monthly	810	Ln10, Col 3	47
48					48
49	TOTAL (lines 35 - 48)	73	\$ 59,517		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brentwood North Healthcare & Rehabilitation Ctr# 0050112Report Period Beginning: 1/01/2010Ending: 12/31/2010**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$11,838
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5, 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,779 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 131,412
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 28,643 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2010

SCHEDULE A

SCHEDULE VII. RELATED PARTIES

Part A. Col.3

3		
OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
Glen Health & Home Management, Inc.	Skokie	Management Company
GlenBar Management Company, Ltd.	Skokie	Management Company
Brentwood Healthcare Real Estate LLC.	Skokie	Building Lessor
Fargo Real Estate & Development, LLC	Skokie	Building Lessor - Management Co.
Therapy Masters	Skokie	Therapy company

See Accountants' Compilation Report

Brentwood North Healthcare and Rehabilitation Centre, Inc.
 Provider I.D. # 50112
 12/31/2010

SCHEDULE B

SCHEDULE VII RELATED PARTIES

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

Name	Compensation Received From Other Nursing Homes						Total
	Glen Oaks Nursing & Rehab. Centre, Ltd.	GlenCrest Nursing & Rehab. Centre, Ltd.	Glen Bridge Nursing & Rehab. Centre, Ltd.	Glen Elston Nursing & Rehab. Centre, Ltd.	GlenShire Nursing & Rehab. Centre, Ltd.	GlenLake Terrace Nursing & Rehab. Centre, Ltd.	
Sidney Glenner	38,732	36,332	33,252	14,264	29,130	32,437	184,147
Jonathan Glenner	10,423	9,777	8,948	3,838	7,839	8,729	49,554
Daniel Glenner	5,736	5,380	4,924	2,112	4,314	4,803	27,269
Elliot Glenner	4,027	3,777	3,457	1,483	3,029	3,373	19,146
David Weinschneider	10,287	9,649	8,831	3,788	7,737	8,615	48,907
Joshua Ray	38,732	36,332	33,252	14,264	29,130	32,437	184,147
Total compensation received from other Nursing Homes	107,937	101,247	92,664	39,749	81,179	90,394	513,170

See Accountants' Compilation Report

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2010

SCHEDULE C

XIX. SUPPORT SCHEDULES

C. Professional Services
Page 21

<u>Vendor/Payee</u>	<u>Type</u>	<u>AMOUNT</u>
Health Data Systems, Inc.	Computers	6,361
Point ClickCare	Computers	2,284
Advanced Answers on Demand	Computers	1,855
Frank Della	Computer Systems Consultant	1,636
RSM McGladrey	Accounting	25,244
Frost, Ruttenberg & Rothblatt	Accounting	375
Much Shelist	Legal	2,554
Prospect Resources Inc	Maintenance Consulting	1,500
Personnel Planners, Inc.	Unemployment Consulting	804
Commitment Consulting	A/R Collections	424
Total Schedule V, Line 19, Col. 3		<u>43,037</u>
Allocated from Management Co:		
Health Data Systems, Inc. - Computer Services		2,023
Clinical Reimbursement Solutions - Accounting		646
RSM McGladrey - Accounting Services		14,986
Harold Geiser - Accounting		558
Frost, Ruttenberg & Rothblatt - Accounting Services		147
Much Shelist - Legal Services		973
Total allocated from Management Co.		<u>19,334</u>

Total allocated from Brentwood Healthcare Real Estate LLC:	<u>0</u>
Total allocated from Therapy Masters:	719
Non-Allowable Expenses:	
Commitment Consulting - A/R Collections	-424
RSM McGladrey - Accounting Fees	<u>-24,571</u>
Total Non-Allowable Expenses:	<u>-24,995</u>
Total adjustments page 21, Sch C.	<u><u>-4,942</u></u>
Total Schedule V, line 19, column 8	<u><u>38,095</u></u>

See Accountants' Compilation Report

SCHEDULE D

XIX. SUPPORT SCHEDULES

D. Employee Benefits and Payroll Taxes
Page 21

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Allocated from Management Co:	
FICA taxes	15,631
FUTA	213
SUTA	512
401K Match	1,064
Insurance - Hospital	14,305
Employee Benefits	1,617
Other Employee Benefits	910
Workers Compensation Insurance	4,511
Total allocated from Management Co.	<u>38,763</u>
Employee Benefits reclassified to Lines 7, 27	-38,763
Allocated from Therapy Masters, Inc.:	
FICA taxes	76,814
FUTA	1,014
SUTA	1,417
401K Match	6,609
Insurance - Hospital	24,782
Workers Compensation Insurance	15,035
Other Employee Benefits	930
Uniform Allowance	632
Total allocated from Therapy Masters, Inc. Co.	<u>127,233</u>
Employee Benefits reclassified to Lines 15,27	-127,233
Total allocated to Page 21	<u>0</u>

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2010

SCHEDULE E

SUPPORT SCHEDULES

Page 17, Line 36

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Due to Third Party	59,465
Accrued 401K	4,820
Accrued Profit Sharing	98
Accrued Management Fees	122,598
Refunds Exchange	19,138
Total, Page 17, Line36	<u>206,119</u>

See Accountants' Compilation Report

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2010

SCHEDULE F

SCHEDULE VI. ADJUSTMENT DETAIL

Schedule A. Nonallowable Expenses

Page 5

<u>DESCRIPTION</u>	<u>AMOUNT</u>	<u>REFERENCE</u>
Patient clothing	-160	43
Non-allowable owner interest expense	-1,092,819	32
Non-allowable owner interest expense	-24,912	32
Non-allowable professional fees	-24,995	19
Non-allowable auto expense - marketing	-4,359	25
Non-allowable Illinois Council on Long Term Care Dues	-8,610	20
Adjust mgt co. med supplies - med'A' to cost	-20,188	10
Adjust mgt co. med supplies - med'other' to cost	-30,494	10
Total	<u>-1,206,537</u>	

See Accountants' Compilation Report

**Brentwood Healthcare Real Estate LLC.
Accrued Real Estate Taxes
12/31/2010**

SCHEDULE G

	Accrued 1/01/10	Payments	Expense	Accrued 12/31/10
Balance @ 1/01/2010:	<u>(143,000.00)</u>		<u>(143,000.00)</u>	
2009 real estate taxes paid		144,214.31	144,214.31	
Estimated 2010 real estate taxes:				
2009 taxes	144,214.31			
Estimated increase	2.50 %			
Estimated 2010 taxes	<u>147,819.67</u>			
USE	<u>148,000.00</u>		148,000.00	(148,000.00)
Totals	<u><u>(143,000.00)</u></u>	<u>144,214.31</u>	<u>149,214.31</u>	<u>(148,000.00)</u>

Real estate tax history:

Year	Amount	Increase	
		\$	%
2007	132,370.06		
2008	139,365.64	6,995.58	5.28%
2009	144,214.31	4,848.67	3.48%

SEE ACCOUNTANTS' COMPILATION REPORT

Provider Name: Brentwood North Healthcare & Rehabilitation Center

Provider I.D. #: 50112

Year Ended: December 31, 2010

SCHEDULE H

Training & Education

Person(s) Attending	Date Attended	Location	Title Sponsor	Total Cost
Lynn Bruch	2/6/2010	Barrington, IL	Advocate Health Advisory A Matter of Balance	45
Social Service, Nursing & Admin Staff	2/25/2010	Riverwoods, IL	Social Work PRN Understanding Depression & Working with Depressed Patients	50
Nursing & Social Service Staff	3/11/2010	Riverwoods, IL	Social Work PRN Assessing for Suicidal & Homicidal Risk	250
Erica Joshua, Raoul Zamora	5/18/2010	Willowbrook, IL	Northern Illinois Affiliate of the WOCN If They Could See Us Now: Nursing & Wound Care Through the Years	100
Nursing & Social Service Staff	6/30/2010	Riverwoods, IL	Social Work PRN Neurology of Good Manners	50
Social Service, Nursing & Admin Staff	9/30/2010	Riverwoods, IL	Social Work PRN Legal & Ethical Issues for Social Service Providers	100
Social Service Staff	9/30/2010	Riverwoods, IL	Joseph Monahan/CCMC Legal & Ethical Issues for Social Service Providers & Case Managers	675
Tisha Evangelista, Peter Deligero, Erica Joshua, Dionne Morris	11/18/2010	Naperville, IL	Illinois Council on Long Term Care In-Depth Training for Wound Care Nurses- MDS 3.0 Update	700

Allocated From Management Company	312
Allocated From Therapy Masters	4,676
Total	<u>6,958</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2010

SCHEDULE I

Page 3, Schedule V, Line 25, Col 8
Other Admin. Staff Transportation

	Gasoline	Mileage Reimburse	Parking	Tolls	Total
Direct Expense	5,100	7,723	34	113	12,970
Non-allowable auto expense - marketing					-4,359
Allocated from Management Company					1,848
Allocated from Therapy Masters					906
TOTAL	5,100	7,723	34	113	11,365

SEE ACCOUNTANTS' COMPILATION REPORT

2009 NO ADDITIONS

		84.9438%	17.13%	16.75%	19.58%	7.01%	15.17%	15.25%	9.10%	100.00%
	<u>2,135,245</u>	1,813,758	<u>310,726</u>	<u>303,882</u>	<u>355,107</u>	<u>127,113</u>	<u>275,156</u>	<u>276,645</u>	<u>165,130</u>	<u>1,813,758</u>
			RECALCULATION BASED ON 2010 CENSUS							
		NURSING HOME	<u>GLENBRIDGE</u>	<u>GLENCREST</u>	<u>GLEN OAKS</u>	<u>GLEN ELSTON</u>	<u>GLENSHIRE</u>	<u>GLENLAKE</u>	<u>BRENTWOOD</u>	<u>TOTAL</u>
		PERCENTAGE	90,627	99,020	105,563	38,877	79,393	88,406	43,478	545,364
		84.9438%	16.62%	18.16%	19.36%	7.13%	14.56%	16.21%	7.97%	100.00%
2010 NO ADDITIONS	<u>2,135,245</u>	1,813,758	<u>301,405</u>	<u>329,318</u>	<u>351,079</u>	<u>129,296</u>	<u>264,043</u>	<u>294,019</u>	<u>144,598</u>	<u>1,813,758</u>

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SCHEDULE K

XIX. SUPPORT SCHEDULES

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F. Dues, Fees, Subscriptions and Promotions

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Illinois Council on Long Term Care Dues	20,448
Village of Riverwoods Elevator Inspection	120
Joint Commission Annual Certification Fee	1,070
Joint Commission Long Term Care Program Fee	1,285
CLIA Laboratory Program Certificate of Waiver User Fee	150
Secretary of State Annual Report Fee	129
Employment Fees	13,500
Non-allowable Illinois Council on Long Term Care Dues	<u>-8,610</u>
Total allocated to Page 21	<u><u>28,092</u></u>

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